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2.3000 continued

a. A general hospital assigned to group one shall be:

1. Located within a metropolitan statistical area in the state of Kansas and have a minimum of 200 general hospital inpatient beds; or
2. Located within the state of Kansas and within 10 miles of a general hospital meeting the criteria set forth in subsection a (1).

b. A general hospital assigned to group two shall be:

1. Located within a metropolitan statistical area in the state of Kansas and have less than 200 general hospital inpatient beds; or
2. Located outside of a metropolitan statistical area in the state of Kansas, and have a minimum of 100 general hospital inpatient beds; or
3. Located within the State of Kansas and within 10 miles of a general hospital meeting the criteria set forth in subsections b (1) or b (2); or

c. A general hospital shall be assigned to group three if it does not meet the criteria pursuant to subsections a or b above and it is located within the State of Kansas.

d. A general hospital shall be assigned to group one if it meets the criteria for assignment to both group one and group two.

e. Any hospital located outside of the State of Kansas, including border cities, shall be assigned to group four. These hospitals shall be assigned a payment rate which is the same as group two hospitals, except that the increase identified in section 2.5000 does not apply to Out-of-State hospitals.

f. Critical Access Hospital: Effective for dates-of-service on or after October 5, 2007, hospitals certified as critical access hospitals by Medicare are treated as critical access hospitals for Medicaid.

2.4000 The DRG Reimbursement System Components

The agency has used the DRG classification published by Centers for Medicare and Medicaid Services for developing the necessary components of the DRG Reimbursement System. In addition, effective Oct. 1, 1992, the Department has established new DRG classifications for neonatal services as indicated below.

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789 Short stay neonates died or transferred (2 day maximum)
790 through 792 No longer used
793 Birth weight > 2000 grams, full term with major problems
794 Birth weight > 2000 grams, full term with other problems
795 Birth weight > 2000 grams, premature or full term, without complicating diagnoses
993 Birth weight < 1000 grams
994 Birth weight 1000 - 1499 grams
995 Birth weight 1500 - 2000 grams
996 Birth weight > 2000 grams, w/ respiratory distress syndrome
997 Birth weight > 2000 grams, premature w/ major problem

After the DRG number reassignments, all these claims became part of the total data base used for the DRG Reimbursement System.

Subsections 2.4100 through 2.4700 provide a discussion of the development of all the system components for use effective January 1, 2005. The discussion flows in the order of the steps performed for the computations involved. For example, the establishment of the data base (Subsection 2.4100) was necessary before cost determination (Subsection 2.4200), outlier claims had to be identified (Subsection 2.4300) prior to separating them out from the data base (Subsection 2.4410).

2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective October 1, 2010, the agency used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending the previous December. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

- crossover claims (Medicare paid by Medicaid).
- swing bed claims.
- claims paid from out-of-state hospitals.
- claims from transferring hospitals (in case of transfers, only the claims from the final discharging hospitals were included in the data base), except for DRG 789..
- adjusted claims (in cases where a hospital resubmitted a claim with corrections, the original claim was excluded from the data base. Only the final paid claim was included).
- interim claims which could not be matched together.

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- claims with unusually low cost data for the given DRG, or other abnormal data.

2.4120 Claims Modified Before Including in the Data Base

Interim claims were identified and matched together to result in either a complete stay or a lengthy stay where no discharge had occurred.

2.4200 Determination of the Costs of Claims

The cost of each claim in the data base was determined using the cost data from the respective hospital's cost report, as discussed below.

2.4210 Cost Reports

The Department used the most recently available unaudited hospital cost reports to obtain the cost data for determining costs of claims.

2.4220 Cost Data

The cost data considered for computing costs of claims included education and capital costs. Indirect and direct medical education costs were later removed, however, as specified in Section 2.4240.

2.4230 Cost Determination

The reimbursable Medicaid/MediKan cost of each claim was computed by applying the per day rates (Worksheet D-1) and cost-to-charge ratios (Worksheet C) obtained from the corresponding hospital's cost report, to the covered Medicaid/MediKan days and ancillary charges on the claim.

2.4240 Hospital Specific Adjustments

Medical Education: Indirect and direct medical education costs identified in the cost reports were removed.

2.4250 Example to Illustrate Cost Determination

Data

- Medicaid days and charges from a claim (the first and third columns in the routine service table and the second column in the ancillary service table).

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2.4250 continued

- Rates and cost-to-charge ratios from the hospital cost report (the second column in the routine service table and the first column in the ancillary service table).

Computations

Routine Cost = No. of Days x Rate
Ancillary Cost = Charges x Ratio

Routine Services	Medicaid/Medikan Days	Rate	Charges	Cost
Routine	6	$247.70	$1,500	$1,486.20
Nursery	0	300.42	0	.00
ICU	1	399.36	400	399.36
CCU	0	399.36	0	.00
Sub 1	0	247.70	0	.00
Sub 2	0	247.70	0	.00
Subtotal - Routine	7		$1,900	$1,885.56

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2.4250 continued

Ancillary Services	Ratio	Charges	Cost
Operating Room	0.673302	$ 150.00	$ 101.00
Recovery Room	0.673302	30.00	20.20
Delivery Room	1.167897	.00	.00
Anesthesia	0.768581	75.00	57.64
Radiology - Diagnostic	0.725719	225.00	163.29
Radiology - Therapeutic	0.725719	.00	.00
Nuclear Medicine	0.587560	.00	.00
Laboratory	0.709475	175.00	124.16
Blood	0.709475	25.00	17.74
Respiratory Therapy	0.338426	.00	.00
Physical Therapy	0.689033	.00	.00
Occupational Therapy	2.700472	.00	.00
Speech Therapy	0.912793	.00	.00
EKG	0.206447	50.00	10.32
EEG	0.206447	.00	.00
Medical Supplies	0.473224	325.00	153.80
Pharmacy	0.437813	400.00	175.13
Renal Dialysis	0.000000	.00	.00
Ultrasound	0.477787	.00	.00
Emergency	1.508338	.00	.00
Subtotal (Used for Other Charges Ratio)		$1,455.00	$ 823.28
Other Charges	0.56650	.00	.00
Subtotal - Ancillary		$1,455.00	$ 823.28
Total Medicaid Charges and Cost		$3,355.00	$2,708.84

Analysis

In this example, the final cost of the claim is $2,708.84.

2.4260 Inflation of the Cost and Charge Data

Due to the variety of cost report time periods and discharge dates present in the data base, all routine and ancillary cost from each claim was inflated to the midpoint of the state fiscal year for which the DRG weights will apply. Inflation is calculated using the CMS Hospital Prospective Payment Reimbursement Market Basket from the most recent quarter available at the time of the update. For ancillary lines, where cost is calculated using charges present on the claim, cost is inflated from the discharge date to the midpoint of the SFY. For routine lines, where cost is calculated using the average cost per day of the hospital's cost report period, cost is inflated from midpoint of the cost report period to the midpoint of the SFY.

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2.4300 Identification of Outlier Claims in the Data Base

2.4310 Mean Costs and Mean Lengths of Stay

After determining costs of all claims in the data base (as discussed in subsection 2.4200), the claims were accumulated by DRG number. The next step was to compute the following for each DRG:

- Mean cost per stay
- Standard deviation of the cost per stay
- Mean length of stay (LOS)
- Standard deviation of the length of stay
- Geometric mean length of stay

2.4320 Establishment of Outlier Limits

Cost and day outlier limits were then computed for each DRG by adding 1.94 standard deviations to the mean as shown in the following formulae:

Cost Outlier Limit =	Mean Cost Per Stay	+ 1.94 x	Standard Deviation of Cost
Day Outlier Limit =	Geometric Mean Length of Stay	+ 1.94 x	Standard Deviation of LOS

Note: The day outlier limits were rounded down to the nearest whole number because portions of a day were not considered as a full inpatient day.

A claim is an outlier if its cost or length of stay exceeds the cost or day outlier limit respectively. Therefore, the costs and lengths of stay of all claims in each DRG were compared with the cost and day outlier limits established as discussed above for the corresponding DRG, to determine which claims were cost or day outliers.

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2.4330 Example of Identifying Outliers

	Days	Cost
Claim # 1 -	1	$1,039
Claim # 2 -	1	972
Claim # 3 -	1	916
Claim # 4 -	1	446
Claim # 5 -	2	1,054
Claim # 6 -	2	495
Claim # 7 -	2	1,976
Claim # 8 -	2	743
Claim # 9 -	3	1,131
Claim #10 -	3	923
Claim #11 -	3	2,479
Claim #12 -	3	1,573
Claim #13 -	4	1,234
Claim #14 -	4	1,196
Claim #15 -	4	1,641
Claim #16 -	4	2,749
Claim #17 -	5	1,586
Claim #18 -	5	1,583
Claim #19 -	5	2,341
Claim #20 -	10	3,314

Computations

Total Cost..... $29,391
Mean Cost Per Stay (Total Cost/Total Claims)..... 1,470
Standard Deviation of the Cost Per Day..... 746

Total Number of Days..... 65 days
Mean Length of Stay (Total Days/Total Claims)..... 3.25
Standard Deviation of the LOS..... 2.05
Geometric Mean Length of Stay. 2.70

Cost Outlier Limit = Mean Cost Per Stay + 1.94 x Std. Dev.
= $1,470 + (1.94 x $746)
= $2,917

Day Outlier Limit = Geometric Mean LOS + 1.94 x Std. Dev.
= 2.70 + (1.94 x 2.05)
= 6.68 days
or 6 days

Analysis

Cost Outliers: All claims with costs up to and including $2,917 (the cost outlier limit) are non-cost outlier claims. Claims with costs over $2,917 are outlier claims. Among the above listed claims, only claim #20 is a cost outlier with a cost of $3,314.

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2.4330 continued

Day Outliers: Claims with lengths of stay of 6 days or less are non-day outlier claims, whereas claims with lengths of stay 7 days and higher are day outliers. Out of the claims listed in this example, only claim #20 with a LOS of 10 days is a day outlier.

2.4400 DRG Relative Weights

The agency developed DRG relative weights specific to the Kansas Medicaid/MediKan utilization of general hospital inpatient services. The weights for low-volume DRGs were determined using DRG weights from external data, with preference given to DRG weights derived from populations expected to be similar to the Kansas Medicaid population.

DRG relative weights are used in conjunction with other components of the DRG reimbursement system for computing payment. Determination of payment is discussed in section 2.5000.

2.4410 Data Base Adjustments for DRG Weight Computations

In computing DRG relative weights the cost of each outlier claim (identified in subsection 2.4300) was capped at the outlier threshold for the DRG.

2.4420 Determination of Kansas Medicaid-Specific DRG Relative Weights

For each DRG the following averages were computed from the adjusted data base:

- average cost per stay;
- average length of stay; and
- average cost per day.

The above "average" costs and LOS differ from the "mean" costs and LOS determined earlier in subsection 2.4300. The data base used for the mean costs and mean lengths of stay in subsection 2.4300 included outlier claims, whereas, the above average costs and LOS were computed from the adjusted data base consisting of non-outlier claims and outlier claims capped at the outlier threshold of that DRG (subsection 2.4410).

An "overall average cost" for each DRG was determined from the adjusted data base. Assigning this overall average cost a weight of 1.00, a relative weight was computed for each DRG based on its average cost per stay determined above, as compared to the overall average cost:

$$\text{DRG Relative Weight} = \frac{\text{Average Cost of the DRG}}{\text{Overall Average Cost}}$$

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2.4430 Example to Illustrate the Computation of Kansas Medicaid-Specific DRG Weights

Data

This example uses the same data as in subsection 2.4330, "Example of Identifying Outliers". Since claim #20 was determined to be both a cost and a day outlier, listed below are the claims, including the capped outlier claims used in computing the relative weight of this DRG:

	Days	Cost
Claim # 1 -	1	$1,039
Claim # 2 -	1	972
Claim # 3 -	1	916
Claim # 4 -	1	446
Claim # 5 -	2	1,054
Claim # 6 -	2	495
Claim # 7 -	2	1,976
Claim # 8 -	2	743
Claim # 9 -	3	1,131
Claim #10 -	3	923
Claim #11 -	3	2,479
Claim #12 -	3	1,573
Claim #13 -	4	1,234
Claim #14 -	4	1,196
Claim #15 -	4	1,641
Claim #16 -	4	2,749
Claim #17 -	5	1,586
Claim #18 -	5	1,583
Claim #19 -	5	2,341
Claim #20 -	6	2,917

Overall Average Cost: $2,106.68
(All claims in data base)

Computations

Total Cost.....$28,994.00
Average Cost Per Stay (Total Cost/Total Claims).. 1,449.70

$$\text{Relative Weight of the DRG} = \frac{\text{Average Cost of the DRG}}{\text{Overall Average Cost of all DRGs}}$$

$$= \frac{1,449.70}{2,106.68}$$

$$= .6881$$

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(2.4430 continued)

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid claims data base, the DRG weight was derived using an external data base derived from the Healthcare Cost and Utilization Project's (HCUP) nationwide inpatient data set, with preference given to populations expected to be similar to the Kansas Medicaid population (e.g. Colorado, Iowa, Illinois, Indiana, Kansas, and Missouri were used in the FY 2007 update). The selection of populations used is subject to availability within the HCUP data set. When this alternative was not sufficient, normalized Medicare weights were utilized.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4445 Hospital Acquired Conditions

Effective October 1, 2008, with Kansas Medicaid's transition to MS DRG's, Medicaid will follow Medicare's policy with regard to a reduced DRG payment for a hospital acquired condition (HAC). Approved inpatient hospital rates are not applicable for HAC's that are identified as non-payable by Medicare. The agency will apply the Medicaid rate reduction for a hospital-acquired condition through Medicaid's use of the MS DRG grouper for DRG assignment.

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2.4450 Modification of Relative Weights for Selected DRG Pairs and Triplets

For DRG "pairs" and "triplets", a base DRG may contain up to three severity classes. A base DRG may have no complications or co-morbidity, complications and co-morbidity (CC), or major complications and co-morbidity (MCC). Severity classes reflect, within a base DRG, that additional diagnosis for a case may significantly increase resource consumption. Each DRG class has a separate DRG number.

During the calculation of the DRG weights, if a lower DRG weight results for a higher severity DRG class, the agency assigns the higher severity DRG a weight that exceeds the lower severity DRG class. For this situation, the agency increases the higher severity DRG by the average percentage increase of the Medicare DRG weights for the type of DRG "pair" or "triplet." The agency performs the adjustment in a manner that ensures total reimbursement for the base DRG is unchanged. This overriding assignment ensures that the higher severity DRG has a higher DRG weight than the lower DRG class.

2.4500 Group Payment Rates

The agency determined group payment rates for the general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment. An adjustment factor of 6.87% was applied to the group payment rates effective October 1, 2010 as a budget neutrality factor.

2.4510 Determination of Group Payment Rates

The same adjusted data base as used for DRG weights (subsection 2.4420) was used for developing group rates. Claims were identified by hospital and then sorted by the three groups based on the hospital assignments to groups. All claims were thus divided into three groups.

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2.4520 Example of Group Rate Computation

The following is a highly simplified example which, while illustrating the methodology used, does not represent actual numbers.

Data

Group 1		Group 2		Group 3	
DRG Cost	DRG Weight	DRG Cost	DRG Weight	DRG Cost	DRG Weight
$1,500	.5000	$1,200	.5000	$1,000	.5000
2,000	.8000	2,000	1.0000	2,000	1.0000
2,500	1.0000	800	.4000	600	.6000
3,000	1.2000	2,500	1.3000		
4,000	1.5000	3,000	1.4000		
1,000	.4000	5,000	1.8000		
6,000	2.2000	1,600	.7400		
4,500	1.4000				
2,500	1.0000				
2,000	.9000				

Computations	Group 1	Group 2	Group 3
Total Cost of Claims	$ 29,000	$16,100	$ 3,600
Total DRG Weight	10.9000	7.1400	2.1000
Total Number of Claims	10	7	3
Average Cost	$ 2,900	$ 2,300	$ 1,200
Average DRG Weight	1.0900	1.0200	.7000
Group Payment Rate	$ 2,660.55	$ 2,254.90	$ 1,714.29

The group payment rate was computed by dividing the average cost by the average DRG weight.

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2.4600 DRG Daily Rates

The agency computed DRG daily rates for all DRG classifications. These rates will be used for computing reimbursement in cases involving day outliers, transfers, and eligibility changes (see subsections 2.5300, 2.5400, and 2.5600).

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

The agency established a cost to charge ratio of Medicaid utilization of inpatient services for each hospital. This ratio shows a comparison of Medicaid reimbursable costs of general hospital inpatient services with the corresponding covered charges.

Cost to charge ratios (CCR's) were calculated using the cost reports submitted by hospitals and charge data from the claims database used to compute the DRG weights and hospital group rates.

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confused with the cost to charge ratios of various ancillary service departments computed in hospital cost reports. The cost to charge ratio for out-of-state hospitals is a statewide average ratio.

2.5000 Determination of Payment Under the DRG Reimbursement System

This section provides policies and methodologies for the determination of payment in various situations under the DRG reimbursement system.

Pursuant to Senate Substitute for House Bill 2912, as passed by the 2004 Kansas Legislature, the state of Kansas plans to spend approximately $100 million from the Health Care Access Improvement Fund in state fiscal year 2005 to improve health care delivery and related health activities.

The specific payment changes approved by the Health Care Access Improvement Panel, created pursuant to the legislation, are as follows:

1) Inpatient Hospital payment rates that were in effect on June 30, 2004 would be increased by 34.4% for all Kansas licensed hospitals except state owned or operated hospitals. Effective March 1, 2006, inpatient hospital payment rates effective February 28, 2006 will be decreased by 6.4%;
2) Inpatient Access Improvement Adjustment payments will be made on a fixed per diem increase and a percentage increase, as described in #1 above, to assure that all Kansas hospitals are treated equitably. The per diem increase is intended to ensure Medicaid payments rise with the hospital volume of Medicaid patient care and that hospitals with low case mix indexes are fairly compensated for their fixed costs, which continue to rise rapidly.
    - Eligibility Criteria
        - All hospitals that receive DRG payments except state owned and operated facilities
    - Payment
        - A fixed per diem payment of $66.50 per calendar year 2004 Medicaid inpatient day paid as of 6/27/2005, excluding Medicare crossover claims and excluding HMO encounter data.

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3) Enhancements for Level 4 Nursery will be made for hospital obstetrical care in rural areas that are challenged with maintaining access to intensive neonatal and post delivery care.

- Eligibility Criteria
  - Rural hospitals with 100 or more Medicaid days in Level 4 nurseries with services during calendar year 2004 paid as of 6/27/2005
  - Rural hospitals are defined as those hospitals in Groups 2 or 3 as described in section 2.3000 of Attachment 4.19-A
  - Level 4 days are defined for both eligibility and payment as services reported on the claim form under Revenue Code 0174
  - Not State owned or operated hospital
- Payment
  - $700 per Medicaid Level 4 nursery day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

4) Psychiatric care enhancement for behavioral health services provided to Medicaid Clients in urban areas. The need has grown as some in patient providers have closed psychiatric units. The psychiatric payment enhancement supplements providers who do not receive the benefit of disproportionate share payments.

- Eligibility Criteria
  - Must meet all of the following:
    - General acute care hospital
    - Hospitals in urban areas are defined as those hospitals in Group 1 as in section 2.3000 of Attachment 4.19-A.
    - Non-DSH provider in State FY 2005
    - Not State owned or operated
    - Psychiatric days are defined for both eligibility and payment as services reported on the claim form under revenue codes 114, 124, 134, 144, and 154.
- Payment

$625 per Medicaid psychiatric day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

5) Rehabilitation services payment for general hospitals with large volumes of Medicaid rehabilitation patients. Due to the variety of rehabilitation patients admited, these hospitals have larger Medicaid fixed costs and more extensive operations.

- Eligibility Criteria
  - General acute care hospital
  - Provides more than 125 Medicaid days of rehabilitation care with services during calendar year 2004 paid as of 6/27/2005.
  - Not State owned or operated
  - Rehabilitation services are defined for both eligibility and payment as services reported on the claim form under revenue codes 118, 128, 138, 148 and 158.
- Payment
  - $600 per Medicaid rehabilitation day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

6) Coronary care unit (CCU) adjustment payments to encourage hospitals with large volumes of Medicaid admissions. It is well documented that coronary care patients do better in facilities with larger service volume. This adjustment payment is designed to encourage high Medicaid hospitals also to be centers for coronary care for our Medicaid population.

Eligibility Criteria

- A Disproportionate Share Hospital (DSH) during State FY 2005.
- Has a Medicaid inpatient utilization rate greater than 23% using the same data as used for the State FY 2005 DSH determination, and
- Provides more than 100 Medicaid CCU admissions with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.
- Not State owned or operated
- CCU admissions are defined for both eligibility and payment as services reported on the claim form under revenue codes 210, 211, 212, 213, 214, or 219.

- Payment
  - $6350 per Medicaid CCU admission as reported with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

7) Trauma hospital payments are designed to offset some of the high Medicaid fixed costs of maintaining a trauma center. This increase in payment for those Medicaid cases that required a trauma center for treatment to offset the additional costs of providing ongoing access to this level of emergency care.

- Eligibility Criteria
  - Non-state owned level 1 and level 2 trauma hospitals as defined by the American College of Surgeons.
  - ICU admissions are defined for payment as services reported under the claim form in revenue codes 200, 201, 202, 203, 204, 206, 207, 208, or 209.
- Payment
  - $400 per Medicaid Intensive care unit (ICU) admission with services during calendar year 2004, including Medicare crossover claims, but excluding HMO encounter claims, paid as of June 27, 2005.

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2.5100 Identification of Outlier Claims.

Each claim that is eligible for an outlier payment, will be tested to determine whether it meets the cost and/or day outlier criteria. If the claim does not qualify as either a cost or a day outlier, the standard DRG payment will be made to the hospital, unless the claim falls under one of the categories discussed in subsections 2.5400 through 2.5720 and another method is used for computing payment.

2.5110 Test for Cost Outlier

The covered charges on the claim will be multiplied by the pre-established Medicaid cost to charge ratio for the hospital (subsection 2.4700) to estimate the cost of the claim. If the estimated cost is higher than the cost outlier limit established for the DRG which has been assigned to the claim, a cost outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5120 Testing for Day Outlier

If the covered length of stay on the claim is higher than the day outlier limit established for the DRG that has been assigned to the claim, a day outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.75

Computation/Comparison

Testing for Cost Outlier

Estimated Cost of Claim	=	Covered Charges x Ratio	
	=	$39,760	x .78
	=	$31,013	

Compare With Cost Outlier Limited $32,899

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Section 2.5130 continued

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare with Day Outlier Limit	67 days

Analysis

Cost Outlier: The estimated cost of the claim ($31,013) is less than the cost outlier limit ($32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:
Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

=	4.2294	x	$2,836
=	$11,995		

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

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2.5310 continued

Example of Computing Cost Outlier Payment:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Charges...$45,980
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a day outlier

Computations

Estimated Cost	=	Covered Charges	x	Hospital Ration		
	=	$45,980	x	.78		
	=	$35,864				
Payment for Cost Outlier Portion	=	Estimated (Cost	-	Cost Outlier Limit)	x	DRG Adj. Percentage
	=	($35,864	-	$32,899)	x	.75
	=	$ 2,224				
Total Payment	=	Std. DRG Pymt	+	Outlier Pymt.		
	=	$11,995	+	$2,224		
	=	$14,219				

2.5320 Day Outlier Payment

The payment for the day outlier portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage.

Example of Day Outlier Payment Computation:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Length of Stay.....73 days
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a cost outlier

Computations

Payment for Day Outlier Portion	=	Covered [Length of Stay	-	Day Outlier] Limit]	x	DRG Daily Rate	x	DRG Adjustment Percentage
	=	(73	-	67)	x	$503	x	.75
	=	$2,264						

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Section 2.5320 continued

Total Claim Payment	=	Standard DRG Payment	+ Outlier Payment
	=	$11,995	+ $2,264
	=	$14,259	

2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier....$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier.....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5340 Pay No More Than Charges

After the determination of the payment, including any applicable outliers, hospitals shall be paid the lesser of the Medicaid allowed amount and their allowed charges. Allowed charges are determined based upon which revenue codes are allowed as covered services.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, or to a psychiatric or rehabilitation wing of the same hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.

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2.5430 Transfer To or From a non DRG Hospital

If the transferring hospital or the discharging hospital is not a hospital reimbursed under the DRG system as identified in 2.1000, reimbursement to the non DRG hospital will be computed according to the methodology for non DRG hospitals.

2.5440 Example of Payment Determination in Transfers

The following situation will provide an illustration of the various payment methods used when a patient is transferred from one hospital to another. Although the situation may not be realistic with regard to the medical treatment provided, it shows all basic payment methods for patient transfers through a single example.

A patient is admitted to a state operated hospital (Hospital A), and after a stay of two days with $1,400 in billed charges, the patient is transferred to a general hospital (Hospital B). Hospital B has the patient for three days and the case is assigned DRG #186. Hospital B is in Group 2. The patient is then transferred to another general hospital (Hospital C) due to complications. The patient is discharged after six days from Hospital C, and is assigned DRG #186. Hospital C is in Group 1.

Payment to Hospital A: Since Hospital A is a state operated hospital, the payment will be determined using the methodology specified in the section on state operated hospitals.

Payment to Hospital B: Hospital B is a transferring general hospital, and will therefore be paid a DRG daily rate for each day of stay, with total payment limited by the standard DRG amount.

Data Used for this example:

DRG Daily Rate	$ 597
DRG Weight	.6515
Group 2 Rate	$2307

The transfer payment will be computed by multiplying the number of days times the DRG daily rate; i.e., 3 times $597, or $1,791. This amount will be compared against the standard DRG amount, and the lesser of the two shall be paid. The standard DRG amount is .6515 times $2,307, or $1,503. Therefore, Hospital B would be paid $1,503.

Payment to Hospital C: Hospital C is a discharging general hospital, and would therefore be paid the standard DRG amount plus any outlier payment, if applicable.

Substitute per letter dated 3/19/01

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Section 2.5440 continued

Data Used for this example:

DRG Weight	.6515
Group 1 Rate	$2836

The standard DRG amount is $1,847.65. If this claim had been a day and/or a cost outlier, an additional payment would be made.

2.5500 Payment for Re-admission

2.5510 Readmission to the Same Hospital

If a recipient is readmitted to the same hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; the reimbursement will be made only for the first admission.

2.5520 Readmission to a Different Hospital

If a recipient is readmitted to a different hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; payment will be made only to the second hospital to which the patient was readmitted. Payment made to the first hospital for the original (first) admission will be recouped.

2.5530 Determination of Payment for Re-admission

Whether the reimbursement should be made for the first or the second admission (i.e., the original admission or the subsequent readmission), will be ruled by the discussion in the preceding subsections 2.5510 and 2.5520. The amount of reimbursement in each situation will be determined as provided in subsections 2.5100 through 2.5400.

Substitute per letter dated 3/19/01"

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2.5600 Recipient Eligibility Changes

If a recipient is determined ineligible for the Medicaid/MediKan Program for a portion of the inpatient stay, reimbursement shall be made to the general hospital only for those days of stay which were also days of eligibility. No reimbursement shall be made for services provided on days when a recipient was ineligible for the Medicaid/MediKan Program.

The payment amount will consist of the DRG daily rate for each eligible day during the inpatient stay in the hospital. No more than the standard DRG payment plus any outlier payment (if applicable), will be allowed as the total payment. Only the Medicaid covered inpatient days and charges will be used for outlier payment computation.

2.5700 Payment for Interim Billings

Hospitals will be allowed to submit interim bills for inpatient stays longer than 180 days. Each interim bill must cover 180 or more continuous days of service except the discharge billing and the federal fiscal year end cut-off billing, each of which may include less than 180 days as the situation may be.

2.5710 Payment for First Interim Billing

The first interim bill will be treated like any other claim, in the sense that it will be tested to determine if it meets the cost and/or day outlier criteria. If the stay covered in the first interim bill does not qualify as an outlier, only the standard DRG amount would be paid. If the claim exceeds the cost and/or day outlier limit(s), an appropriate outlier payment will be made in addition to the base amount.

2.5720 Payment for Second and Subsequent Interim Billings

At the time of each interim bill after the first, an outlier payment amount will be determined using the cumulative cost and days since the date of admission through the last service date included in the current interim billing. One of the following two situations may occur:

Up to 360 Days: Up until 360 days of continuous stay, the Department will authorize the fiscal agent to pay the higher of cost and day outlier amounts for each interim bill.

Longer than 360 Days: When the stay becomes longer than 360 days, only day outlier payments will be made.

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2.6000 Settlements and Recoupments

There shall be no year end settlements under the DRG reimbursement system with the exception of critical access hospitals, which are settled to cost as noted under 3.1000. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from The DRG Reimbursement System

Reimbursement for heart, liver and bone marrow transplant services shall be excluded from the DRG payment system. Reimbursement for these transplants shall be based upon the lesser of reasonable costs or customary charges, contingent upon transplant surgery. Due to the unusual nature of these services, negotiated rates which pay no more than the DRG daily rate may be paid. For services provided prior to the transplant surgery, or if transplant surgery is not performed, reimbursement shall be made according to the DRG payment system.

3.1000 Critical Access Hospital Reimbursement

Effective for the reimbursement of inpatient fee-for-service claims for dates of service on or after October 5, 2007 critical access hospitals (CAHs) will be cost settled based on 100% of the reasonable cost of providing the services. Reasonable costs will be determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of cost or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Subject to the 96-hour average for inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished to hospital inpatients.

1) Allowable Medicaid costs are defined as the costs Medicare defines as allowable on the Medicare finalized cost report. The Medicare fiscal intermediary's review of the Medicare cost report is relied on for the determination of reasonable costs and the finalized Medicare cost report will be used for determining final Medicaid allowable costs. CAHs will report Medicaid fee-for-service claim Inpatient charges. For the cost report settlement, the cost report cost-to-charge ratios are applied to the appropriate billed Medicaid charges by cost center to determine Medicaid reimbursable ancillary costs. Medicaid patient days are multiplied by the routine cost per-diem per the Medicare cost report for determining Medicaid routine cost. The sum of these components will be the Medicaid reimbursable cost for all Medicaid inpatient fee-for-service claims.

2) Inpatient CAH interim payments will be made using the established DRG rate times the applicable DRG weight factor. Payment will be the resulting interim cost amount less any applicable deductions necessary to arrive at the Medicaid net reimbursement amount. Upon receipt of the finalized Medicare cost report, interim payments made using the DRG rate are settled to cost based reimbursement using Title XIX data filed on the Medicare cost report.

3) CAHs will be permitted to request interim Medicaid cost settlements by filing an interim Medicare cost report. KHPA will consider issuing an additional interim payment during the period. The interim cost report will be used for calculating and issuing an interim

lump sum payment. Final cost settlement will be issued upon receipt of the finalized Medicare cost report. CAHs are required to file a copy of the finalized Medicare cost report, including completed Medicaid fee-for-service worksheets, with Kansas Medicaid upon receipt of the finalized Medicare cost report from the Medicare Administrative Contractor. Underpayments will be issued to the CAH. Overpayments will be recouped from the CAH through offset or billed to the CAH. The CAH must repay the overpayment within 60 days of determination.

4.0000 Reimbursement for Inpatient Services in State Operated Psychiatric and Large Public Kansas Teaching Hospitals

Reimbursement for inpatient services in state operated psychiatric hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals. These costs shall include Medicare allowable costs, including but not limited to malpractice, capital, physician services, and education as allowed under federal law. Reimbursement for inpatient services in large public Kansas teaching hospitals shall be paid as a percentage of charges with a maximum of 100%. Payment rates shall be established based upon a review of the cost reports and the federal upper payment limit to insure that no more than 100% of charges is paid as well as no more than the federal upper payment limit is paid. A review of their cost report shall also be made to estimate reasonable cost. This would not include physician costs, but would include all other costs that were identified in the state operated psychiatric hospitals above. The minimum payment rate that would be made would be the lesser of the billed charges and 85% of the estimated reasonable cost. The specific rate for large public Kansas teaching hospitals will be negotiated with the provider(s) to comply with federal upper payment limits. The payment method described for large public Kansas teaching hospitals is effective with dates of service on and after 7/1/2003.

4.1000 Reimbursement for Inpatient Services in Border City Children's Hospitals

Reimbursement for inpatient services in border city children's hospitals is determined upon the Standard DRG payment plus an additional amount for outlier claims. Outlier payment for border city children's hospitals are calculated consistent with the method described at 2.5100 and 2.5300; however, due to the high volume of outlier services provided by border city children's hospitals, the outlier DRG adjustment percentage will be a percentage specified for border city children's hospitals. The agency will review the percentage annually and will adjust to ensure that recovery of costs for the hospital is at a level consistent with the Kansas statewide average ratio. The receovery of costs ratio is the hospital reimbursement divided by the hospital-specific costs incurred for providing the services. If the existing outlier adjustment percentage is resulting in payments that ensure coverage of costs is at a level consistent with other Kansas hospitals, the agency will not adjust the percentage. The outlier adjustment percentage for border city children's hospitals will be effective July 1.

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage specified for border city children's hospitals. The cost of the claim is determined by multiplying the border city children's hospital's cost-to-charge ratio times the claim billed and covered charges. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made. The payment for the day outlier

portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage for border city children's hospitals. If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

The outlier adjustment percentage for border city children's hospitals is determined based on a review of the cost report, historical claims data and an estimate of the costs incurred by the children's hospital for them providing the care. The outlier adjustment percentage seeks to ensure Medicaid payments reimburse border city children's hospitals approximately the same proportion of the costs of providing the care as other Kansas hospitals receive, on average, for Medicaid services. For instance, an outlier adjustment percentage of 110% results in estimated Medicaid payments that will cover approximately 82% of the costs of the children's hospital's costs of providing the care. The outlier percentage will be reviewed annually to determine the estimated coverage of costs.

The outlier adjustment percentage for border city children's hospitals is 110% effective July 1, 2008.

The agency will review the adjustment percentage each year, but may not change the adjustment percentage if the existing percentage is resulting in reimbursement that ensures payments to the hospital are at a cost recovery level that is similar to the average for Kansas hospitals. The agency will adjust the percentage if it is determined that reimbursement is not covering costs at a level consistent with the Kansas hospital average.

The estimate of costs incurred by the border city children's hospitals will be determined using the cost-to-charge ratio from the border city children's hospital Medicare cost report. The agency will multiply the cost-to-charge ratio times billed charges for determining the hospital's costs for the services provided.

The agency will determine the level of costs reimbursed at other Kansas hospitals through an analysis of each hospital billed charges times the hospital-specific cost-to-charge ratio derived from each hospital's Medicare cost report. The agency then divides aggregate payments to the hospitals by aggregate costs for determining the averaged cost recovery ratio for Kansas hospitals.

The agency will utilize claims data from the MMIS for the latest fiscal period for the border city children's hospitals. The agency will recalculate reimbursement for the claims data in Excel and reconcile, on a claim-by-claim basis, to the payments reported in MMIS. The agency recalculates outliers using the formulas in Excel, which allows the agency to determine the impact of setting the outlier recovery ratio at various levels. The agency examines the resulting dollar increase in reimbursement from an increase in the outlier adjustment percentage by substituting various ratios within the outlier formula. The agency adds the increase in outlier reimbursement to the actual reimbursement. The agency then divides this amount by the hospital's cost for determining the percentage of costs recovered for the border city children's hospital. The goal is to derive a percentage that results in reimbursement that is similar to the average for other Kansas hospitals.

The base data used for determining the outlier adjustment percentage is from the most recent available Medicare cost report data for the border city children's hospital. In addition, the base claims data is from the hospital's most recent 12-month cost reporting period. In general, the base data is the most recent historical data available.

Examples:

Border City Children's Hospital Billed Charges
X Border City Children's Hospital Cost-to-Charge Ratio
=Costs of Services Provided to Border City Children's Hospital

Actual Allowed Reimbursement for Border City Children's Hospital
Divided by Costs of Services Provided to Board City Children's Hospital
=Percent of Actual Costs Recovered by Border City Children's Hospital

Allowed Reimbursement to Kansas Hospitals
Divided By Aggregate Cost of Services Provided to Kansas Hospitals
=Average Percentage of Costs Recovered by Kansas Hospitals

Compare Border City Children's Hospital Recovery Percentage to Average Percentage of Costs Recovered by Kansas Hospitals

Reimbursement to Border City Children's Hospital with Outlier Adjustment Percent at 75%
In addition, the Increase in Reimbursement Determined Based on Recalculated Outliers at a Higher Recovery Ratio
=Revised Border City Children's Hospital Allowed Reimbursement

Divide Revised Border City Children's Hospital Reimbursement by Costs of Services Provided to Border City Children's Hospital

Compare the revised ratio to the ratio for all Kansas Hospitals.